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RURAL MENTAL HEALTH.

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THE PROBLEMS OF PROVIDING MENTAL HEALTH PROGRAMS FOR RURAL AREAS MAY BE DIVIDED INTO TWO SECTIONS. IN THE FIRST SECTION, THE PROVISION OF MENTAL HEALTH SERVICES TO RURAL POPULATIONS, A REVIEW OF FEDERAL LEGISLATION PERTAINING TO MENTAL HEALTH LEADS TO THE CONCLUSION THAT REGULATIONS WERE WRITTEN FOR URBAN AREAS TO THE EXCLUSION OF RURAL AREAS. FOR EXAMPLE, THE STRICT ENFORCEMENT OF SOME OF THESE REGULATIONS WOULD NOT PERMIT THE DIFFERENT APPROACHES IN RURAL AREAS NECESSARY TO PROVIDE SUCH MENTAL HEALTH SERVICES AS DAY CARE, EXTENSIVE SPECIALIZATION, AND THE CONSULTATION PROCESS. THE SECOND SECTION RELATES TO THE OPPORTUNITIES FOR MEANINGFUL SERVICE WHICH RURAL YOUTH MAY EXPERIENCE WHILE WORKING IN MENTAL HEALTH PROGRAMS. DUE TO THE SHORTAGE OF MENTAL HEALTH PROFESSIONALS, COLLEGE STUDENTS AND OTHER YOUTH HAVE BEEN UTILIZED TO PROVIDE CERTAIN ASPECTS OF MENTAL HEALTH CARE. THIS PRACTICE HAS PROVEN QUITE SUCCESSFUL, BOTH IN PROVIDING MENTAL HEALTH SERVICE, AND IN GIVING YOUTH A SENSE OF WORTH AND DIGNITY WHILE PERFORMING A MEANINGFUL SERVICE FOR MANKIND. THIS SPEECH WAS PRESENTED AT THE NATIONAL OUTLOOK CONFERENCE ON RURAL YOUTH, OCTOBER 23-26, 1967, WASHINGTON, D. C., SPONSORED JOINTLY BY THE U. S. DEPARTMENTS OF AGRICULTURE, HEALTH, EDUCATION, AND WELFARE, INTERIOR, AND LABOR, OEO, AND THE PRESIDENT'S COUNCIL ON YOUTH OPPORTUNITY. (ES)

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Special Session on Health Status and Health Services for Rural Youth

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# RURAL MENTAL HEALTH

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Ladies and Gentlemen, I have been asked to talk about mental health programs for rural areas. I would like to divide my topic into two major sections, 1) the provision of mental health services to rural populations and 2) the opportunities for meaningful service for rural youth in mental health services. In regard to the first topic, a reading of the federal legislation on mental health very quickly brings one to the conclusion that these laws were written for urban areas and that the regulations, if rigidly enforced, would exclude truly rural areas from the benefits of our new federal legislation. The Community Mental Health Centers Act speaks of 150,000 people being the minimum to be served by a community mental health center. For many rural areas, this is an impossible requirement as the distances to be traveled to obtain these services would be much too long and the goal of the federal legislation, which is to keep the psychatric patient as close to home as possible, could not be fulfilled if the standard of 150,000 people for any one community mental health center were enforced. After extensive conversations with our congressional delegation, we finally were able to put through authorization to develop some community mental health centers which will serve a population of 40,000. In the State of Vermont, this means that for some services, there will be people who will have to travel as long as an hour and a half one way. If the 150,000 population figure had been enforced, there would have been people who would have had to travel at least two and a half hours one way. Actually, the community mental health center authorized for 40,000, which visualized the establishment of one center with one satellite clinic, will make available most services to all of the population within a half-hour drive. What can be said about the community mental health legislation is true of much of other new federal legislation. Rural communities must fight to be allowed to share in the benefits of this new legislation. They must break through the regulations which have universally been designed for urban areas.

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There is a tendency in the writing of national legislation to think that programs which are useful in urban areas can be translated directly to rural areas. This is not so. Let me give you a specific example. The community mental health center legislation visualizes day care as an important part of the services to be provided. Day care makes it possible for a patient to come into the hospital by the day and be treated, but to be home at night. In an urban area with ready access to public transportation, this is quite feasible. In a truly rural area where often another member of the family would have to transport the patient, often as far as an hour to an hour and a half in each direction, this would involve the family in four to six hours of transportation each day to make the service available to the sick member of the family. This obviously becomes quite unrealistic and, therefore, day care as designed for the urban area is just not applicable for the truly rural area.

Another difference in providing services to rural areas is that extensive specialization of services becomes unworkable. In a city, it is quite feasible to have a child guidance clinic to treat children, an alcoholism clinic to treat alcoholics, a separate after-care clinic to treat adult patients who have been discharged from a mental hospital, an adult mental health clinic to deal with minor psychiatric problems in adults in the community. If this kind of service pattern is followed in a rural area, what you find is that the most highly paid, or in other words, most expensive professional people spend all of their time traveling for one day a month clinics in outlying areas. For each hour of clinic service, one hour of travel time is required. This becomes a highly inefficient use of scarce professional personnel. In a rural area, all purpose clinics are needed where the same professional person can take care of all these different kinds of problems backed up by specialists available at nearby medical centers for consultation via telephone. This limits the number of the professionals who spend a great deal of time traveling and it makes it possible for the individual professional who goes to a particular community to become sufficiently acquainted with that community so that he can learn how to utilize the available resources in that community. Let me take an example: In a small town of 11,000, a child guidance team spent one day a month, an adult psychatric team spent one day a month, a physician who ran a clinic for alcoholics spent one day a month, and a physician who supplied after-care for State hospital patients spent one day a month. All of these people were obviously able to see their clients only once a month at most and they had little opportunity to become acquainted with the community in which they were working. Their work never became integrated with that of the other social agencies, clients who needed urgent help between visits received none. If, on the other hand, you would have one general team visiting this community one day a week, patients when necessary could be seen on a once a week basis for more intensive care and when more specialized information was needed, this team could, by telephone, consult

with the specialists available at a nearby medical center. Such a team would have a much greater chance to become knowledgeable about the community in which they were working and everyone has agreed that such a knowledge of local conditions is essential to the best handling of patients. Rehabilitation and job placement are often essential ingredients of good mental health treatment. This requires a good knowledge of the resources available within a community for such job training and of the actual jobs available for effective service.

Modern community mental health programs utilize the process of consultation extensively. The professional talks with other types of professionals such as school teachers, public health nurses, general practitioners, probation officers, welfare workers, ministers, who themselves are involved in helping people with problems. By giving help to these other professionals, their effectiveness is increased and the number of clients who need direct services from mental health professionals is reduced. In a rural program, it often becomes necessary to design these kinds of programs along different lines also. In a city, it is easiest to have meetings first with school teachers, another meeting for public health nurses, another meeting for ministers, etc. In a rural community, it is often far superior to go to a small town and meet there with all the different people involved in giving care. So that in a small community, one would meet with the local welfare worker, the local public health nurse, some people from the local school, some of the local ministers, some of the local doctors, the probation officer responsible for this area, etc. A very frequent benefit from this kind of a program is that one suddenly discovers that a number of different agencies are working with the same client, that each is working in isolation and does not know what the other is doing. By having consultation meetings which cut across agency lines, one is able to coordinate the program for each individual client, to decide who will do what and to agree upon common goals. When you first start these kinds of sessions, it is not unusual to find that perhaps one worker is working with a mother to help her get the strength to leave an impossible alcoholic husband while the other worker is working with the husband to encourage him to stay with his wife.

People often have rather romantic ideas about the country, ideas which go so far as to assume that rural areas do not have the same kind of mental health and social problems that city areas have. We do have statistics which indicate that our worst ghetto areas in large cities where there is extensive social disorganization do produce a much higher rate of social breakdown than other parts of our cities or rural areas. But, except for these very sick areas, the incidence of most emotional disorders is the same whether we look at a city, a suburban area, a town or a rural village. Certainly some of the things which give us special difficulties in a city, such as the social and racial segregation we find in many school systems, can be avoided in the rural

area, where usually there is one school to serve a whole area and all the children in that area, regardless of what race or what economic class they are, attend the same school. This does reduce the social ostracism of the poor and of minority groups and makes it easier for members of a lower class family to both feel that they can move upward and to actually move upward. In rural Vermont, our delinquency rates are definitely lower than they are in urban areas. One major reason for this is probably that in one's home town, one is very well known and, therefore, cannot afford to get involved in criminal activity. The chance of being recognized by someone is so great that the odds for getting caught become too great. Of course, with the greater availability of automobiles, this benefit is disappearing in that young people can travel to another town where they are unknown and where, therefore, they can then engage in criminal activity. In most rural areas, the social situation is such that the middle class and upper middle class members predominate and we do not get the problems we see in cities where either large population pockets of the very poor encounter only each other or, on the other hand, groups of various other social classes remain limited in their contacts to other members of their own social class only. One problem related to rural mental health programs remains unsolved. Professional workers in the mental health field, especially psychiatrists, seem city bound. Few of them have the courage to explose themselves to the high visibility that goes with work in a rural area nor to accept the challenge of being truly on their own, fully responsible for their successes and failures. In a rural setting, one's failures do not disappear as they do in the city. They remain clearly visible.

Now let me address myself to the second aspect of my talk, namely the opportunities for rural youth for meaningful service in a mental health program. The need for young people to have an opportunity for commitment to a cause is highlighted by the popularity of our Peace Corps and Vista Programs. We have become more and more aware that young people, for their own development, need such opportunities for service. At the same time, in rural mental health programs, we face a lack of professional personnel. As I said before, psychiatrists are loathe to move to the country and the same can be said for all other professional mental health workers.

While running a mental health program in northern New York State, I was faced with the dilemma of many children who needed mental health services and a lack of professional resources to provide these services. As I thought about the problem, I became impressed by the fact that the essential ingredient of the service that we offered to most children was one of interest and companionship. I began to wonder whether it was really necessary to have all sorts of graduate degrees in order to be able to provide this type of interested companionship. At the same time, I was the psychatric consultant to a college and had been struck

there by the need of the college students to be involved in some meaningful work. Many of them felt at sea in their studies and felt somewhat guilty that they were not doing anything meaningful for the larger community in which they lived. It was not far from these two insights to come up with the idea of putting these two needs together, namely, the needs of the children with emotional problems for an understanding and warm relationship and the need of the college students for some meaningful service. We therefore, back in 1955, began the use of college students on a voluntary basis for what you might call companionship therapy with emotionally disturbed children. When, in 1958, I moved to Vermont, I brought this idea with me and we then received a grant from the National Institute of Mental Health to try this idea out much more extensively.

We found that the children did just as well or perhaps better than they did with ordinary clinic therapy and that the college students found in this work the kind of meaningful experience they were looking for which often helped them find their own directions or helped them make choices for professional careers for their own futures. The only students with whom we had any difficulty were the Psychology majors who, of course, wanted to be therapists rather than companions and who wanted to see whether their little charges were, in fact, the way their Psychology textbooks described them. We now feel that this kind of companion therapy or, as it was called in a recent paper, "Amica-Therapy," should not be viewed as a second best method of treatment to be employed because there is a shortage of professional therapists but that for many cases, it should really be considered as the treatment of choice and that is how we use it now. We have involved a whole series of both junior and senior colleges in the project. The children who need this kind of help are selected by the mental health clinic in the area, and some one person at each college is responsible for recruiting volunteers and then seeing to it that these volunteers keep their appointments with their assigned children. All the volunteers working in the program are given an opportunity to meet together with a staff member from the clinic approximately once a month when they discuss any questions which may have arisen. They are, of course, always free to call the clinic by telephone if any acute situation should arise. Actually, in our experience, this has never happened. We give the students very little guidance in what they should do and it has been fascinating to see how the students, left to their own devices, very soon find activities which are suitable both for the particular child and for the particular college student.

While in New York State, we also explored an adaptation of this program where we used high school seniors for work with elementary school students, often on a tutorial basis. This, too, can be very successfully developed. The thing which defeated us was the fact that we were dealing with a union school and we could not cope with the bus schedule.

In other words, the only time available for this program was after school hours, but then there would be no bus transportation home for the elementary school children involved. I am sure that with a sympathetic school administration even this difficulty could be resolved.

Opportunities for rural youth to become involved in meaningful services can also be expanded in other areas. If there are special classes or schools for the retarded or a mental hospital within the area, such institutions can use the volunteer services of young people to excellent advantage. As part of the aftercare services for patients discharged from mental hospitals, there is usually a great need for the organization or some social activities for these ex-patients. Again, this is an area in which young people can make a great contribution and find another opportunity for meaningful service.

All children have need of meaningful relationships with adults other than their parents and teachers. The 4-H Clubs and Future Farmers of America have provided this for many, but much more could be done, particularly for the children from the most disadvantaged families. Here again is an opportunity for meaningful service for young people in rural areas and a true challenge to them to evolve programs which will allow these children from disadvantaged families to become integrated into our greater American society.

I am convinced that there are some very real advantages to growing up in a rural area. Over the last century, a large percentage of the most important contributors to the development of our society were people who grew up in rural areas and then, in young adulthood, migrated to our cities. The values and viewpoints that were impressed upon them in their rural life were a most important ingredient for the later contributions they made to our society. Rural living up to now does a better job of reproducing, or recreating our social values, a process which is crucial for the survival of any society. Until we solve the riddle of our cities, so that the cities become able to recreate and reproduce our social values, we will be dependent on our rural areas to carry on the main share of this essential social function.